Table III shows the gradual increase in the number of Ante-natal Clinics since the more extensive service established in 1925, when the number was sixteen. These clinics were established for free service to expectant mothers. The majority of them are conducted by the Plunket Society, which is gradually extending its activities in this branch of maternal and infant-welfare work. All the public clinics are in charge of registered midwives, most of whom have had special training to fit them for this responsible task. The necessity of obtaining medical advice in any case of suspected abnormalities and for all patients at least once, in the case of primiparæ early in pregnancy, and in all cases if possible during the last fortnight, is impressed upon the nurses conducting the clinics. Everything possible is done to promote co-operation between the nurse conducting the clinic and the medical man or midwife who is to attend the patient during delivery. The clinics established in connection with public maternity hospitals have at all times medical men available for those patients attending the clinic who are going to enter the hospital. The others are referred to their own medical man, and printed circular letters are available for the use of all nurses when sending on copies of the charts. In the majority of cases I believe that it is possible to obtain helpful co-operation between both doctor and nurse. Where this exists the work of these clinics is undoubtedly of great value. Where it does not exist it is equally certain that the work is incomplete. There have been and always will be difficulties in individual cases in gaining the necessary co-operation, but a little forbearance and good will on both sides should make this possible to the advantage of all concerned, particularly the patient. In view of the fact which I have stated in a previous paragraph, I am still hopeful that our high death-rate from the various manifestations of toxæmias of pregnancy will ultimately be reduced. There is no doubt that at present the return is much higher than would be the case if the proper co-operation could be obtained of patient, doctor, and nurse—all interested in this work.

MATERNITY HOSPITALS.

At the end of the financial year the hospitals of New Zealand mainly providing maternity accommodation consisted of 5 State (St. Helens) maternity hospitals, providing 98 beds, 70 maternity hospitals under the control of various Hospital Boards providing approximately 502 beds, and 190 private hospitals providing 915 maternity beds, a total of 1,515 maternity beds, or an average of approximately one bed to every thousand of population. These hospitals, many of which provide only from three to four beds, are fairly evenly distributed over the country, and provide a valuable and essential means of giving a good maternity service in all but the most remote and thinly populated districts of New Zealand. Their even distribution avoid any marked disparity in the risks to the rural and urban population of New Zealand; approximately 70 per cent. of the confinements were conducted in them. Details with regard to these hospitals are set out in Tables IV and IVA. There is now but little difference in the death-rate of the different groups of hospitals. Variation from year to year during the period 1929–33 is shown in Table IVA. It is particularly gratifying to note that the death-rate of the mixed hospitals (Group IV), which in most cases are primarily maternity hospitals, but also admit medical and surgical cases, has shown a very marked reduction since 1929. In that year it was established that the death-rate for this group of hospitals, comprising 71 hospitals, was 8·23 per 1,000, and that this excessive death-rate was due to puerperal sepsis. It could only be concluded that the prevalence of puerperal sepsis in these hospitals was due to the transfer of infection from the medical or surgical cases admitted thereto. The conditions under which each hospital was being run were considered, and where the nursing staff or the facilities in the hospital were insufficient to ensure safety to the maternity patients from the above-mentioned risk, septic surgical cases were excluded. This applied to approximately 66 per cent. of the hospitals, and the remaining one-third of the hospitals were still allowed to receive such cases providing it was found possible with proper care to eliminate the risks to maternity patients. It would have been easier to have excluded all such cases from these hospitals, but such a course, while definitely avoiding the risk to maternity patients, would have derived patients requiring medical and surgical treatment from the benefits to which they were entitled. The less drastic precautions taken have proved the soundness of the policy adopted, inasmuch as while the death-rate as pointed out above was 8·23 per 1,000 in 1929 it has fallen by successive steps and in 1933, as is shown in the table, was 2·97 per 1,000. I must point out that the death-rate for all maternity hospitals as shown in these tables is not comparable with the general maternal death-rate for the country inasmuch as the calculation is per 1,000 confinements and deaths from abortion and ectopic gestation are not included as such cases are not admitted to maternity hospitals.